# AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS

**Individual's Name** Click here to enter text.

**Provider Agency who has the individual's Records:** DBHDS

**Person, Agency, or Health Care Entity to whom disclosure is to be made** –
(Both the Bridge Funding Applicant and the DBHDS should be listed here)
Click here to enter text. (Bridge Funding Applicant #1)
Click here to enter text. (Bridge Funding Applicant #2)
Click here to enter text. (Bridge Funding Applicant #3)
Click here to enter text. (Bridge Funding Applicant #4)

Community Integration Team (DBHDS)

**Information or Health Records to be disclosed**: Discharge Plan and Discussion Record, Event data, explanation of the reason for infrastructure grant funds, hospitalization records, medical records if needed to support staffing levels or nursing needs, Behavior Supports Plan and data, explanation of reason for requesting funding (tied to Discharge Plan and Discussion Record

## *PURPOSE OF DISCLOSURE OR AT THE REQUEST OF THE INDIVIDUAL*

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records for purposes related to obtaining non-Medicaid funding under Virginia's Bridge Funding Program. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization.

I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization.

A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included within my health records and as part of the Bridge Funding Application. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

## AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS

**Individual's Name** Click here to enter text.

This authorization expires on (date) or (event) after all BF payments have been dispersed or funding is no longer needed.

_____ _____

Signature of Individual/AR Date